Medicaid Spend-down

What is it?

Spend-down is a provision that allows a person whose income is more than the standard to receive some assistance with medical bills under Medicaid. The amount of a person's spend-down is the amount of medical expenses that Medicaid won't pay for *every month*.

When a Medicaid applicant's income is more than the income standard, proof of medical expenses is required. The person is eligible for Medicaid with a spend-down if medical expenses that are not subject to or paid by insurance are more than the spend-down amount.

How does it work?

Beginning January 1, 2006, spend-down works like an insurance deductible. Medical providers file their claims for services with Medicaid and the spend-down amount is deducted. A claim to Medicaid is filed after Medicare or other insurance has processed the claim. Once the spend-down amount is satisfied in a month, Medicaid will pay for all other covered services. In a few situations, members must provide bills or receipts to their Local Office of Family Resources. These expenses are transmitted to the Medicaid computer to satisfy spend-down.

This leaflet contains information you need to know as a Medicaid member on spend-down. At first it may seem like a lot to read and understand, and you will probably have a lot of questions. Save this so you can refer to it as questions come up. If you need another copy, you can get one at your Local Office of Family Resources.

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Definitions

1. Claim – When you receive a medical service, your provider files a "claim" with the Indiana Medicaid program in order to receive payment. Claims can be filed electronically or on a paper claim form. Providers receive information back from Medicaid that shows them how their claim was processed and how much, if anything, they can bill the member for his or her spend-down obligation.

2. Non-claim – These are medical expenses that must be submitted to the Local Office of Family Resources. They are referred to as "non-claims" because they cannot be filed as regular claims to the Medicaid program. More about non-claims is on Page 5.

3. Satisfy spend-down – This is the process of incurring allowable medical expenses during a month up to your spend-down. Medicaid will pay for covered services once your spend-down is satisfied. Similar phrases that you likely will hear are "crediting spend-down" and "applied to spend-down". When the Medicaid computer processes a claim (or a non-claim), it checks first to see if spend-down is satisfied. If it is not, the amount of the medical expense "credits spend-down" or is "applied to spend-down". This process determines how much you will owe each of your medical providers whose claims were used to satisfy your spend-down.

4. QMB – This is a type of Medicaid that pays for the Medicare Part A and Part B premiums, coinsurance and deductibles. QMB stands for Qualified Medicare Beneficiary. Some members have only QMB Medicaid. However, some spend-down members have QMB coverage *in addition to* regular Medicaid. Members with both types of Medicaid will have their out-of-pocket costs for Medicare services paid for by QMB, not Medicaid spend-down. Providers bill Medicare first, then the claim goes to Medicaid. Any remaining balance is covered by QMB, so there is no expense to be applied to spend-down. If you are not sure whether you are a QMB, contact your caseworker at your Local Office of Family Resources.

5. Couple Spend-down – When both the husband and wife are on Medicaid spend-down, they have *one* spend-down for the both of them. Whenever one has a medical service, the amount of the expense is automatically credited for both spouses.

6. Full Coverage Medicaid – This refers to the member's benefit package under Medicaid. A member with full coverage can access all of Medicaid's covered services.

7. Emergency Services Only Coverage – This refers to the limited services that some immigrants have under Medicaid. With this coverage, the member may or may not have a spend-down.

8. Medicaid Spend-down Summary Notice – On the second business day of every month, the Spend-down Summary Notices are issued to members who had medical services that were applied to their spend-down during the previous month. Once spend-down is satisfied for a month, the claims that Medicaid pays for services in that month do not show up on the Spend-down Summary Notice. More about the notices is on Page 6.

Examples and Frequently Asked Questions

Here is a simple example of how spend-down works. This example will apply to many members.

ED

Ed receives Social Security Disability but has not been drawing it long enough to be entitled to Medicare. His Medicaid spend-down is $55. He takes 4 prescription medications. On January 4, he calls in his refills and then goes in to the pharmacy to pick them up. His pharmacist charges him $55 plus $9.00 for the copayments. Here's what happened:

Rx 1: Cost was $75. Ed's $55 spend-down was applied to this prescription. The $3.00 co-payment was included. Medicaid paid the remaining cost of this prescription.
Rx 2: Cost was $78.00. Medicaid paid for this. Ed owes the $3.00 copayment.
Rx 3: Cost was $14.00. Medicaid paid for this. Ed owes the $3.00 copayment.
Rx 4: Cost was $54.00. Medicaid paid for this. Ed owes the $3.00 copayment.

The $9.00 in copayments is carried forward to the next month's spend-down. In February when Ed gets his refills, his starting spend-down balance is 46.00 because the $9.00 co-payments from January have already been deducted.

The next example should be helpful to members who have QMB coverage.

NELL

Nell has QMB and full coverage Medicaid with a spend-down of $115. On February 6, she goes to her doctor. There is no charge to her for this visit. Medicare will pay for part of it and QMB Medicaid will pay the remaining. Her doctor ordered an x-ray and she goes the next day to the hospital to get the x-ray. The hospital x-ray department does not charge her because Medicare will cover the service and QMB Medicaid will cover what Medicare did not pay. Later in the month, Nell goes to the dentist. She knows Medicare won't cover this visit and she knows she hasn't satisfied her spend-down for the month. Her dental office tells her they will bill Medicaid and when informed how much of the cost was applied to spend-down, they will send Nell a bill. The dental office further explains that they will expect payment from Nell when she receives her Spend-down Summary Notice. This Notice will show how Nell's medical expenses were applied to her spend-down and the amount her providers can bill her.

Nell understands that she will owe $115 to her medical providers. For the month of February, her only out-of-pocket cost for medical care was her dental care. When her monthly Spend-down Summary Notice arrives in the mail, it shows that she owes her dentist $115 of the total cost of $214.34.

Question: I've been on spend-down for several months. I don't have Medicare. I get part of one of my prescriptions filled to meet my spend-down and pay the pharmacist. My pharmacist faxes the receipt to my spend-down clerk. Then I have to wait until the effective date gets entered into the computer so that I can go get the rest of my medicine. Starting in January, what will change for me?

Answer: The process will be much easier. All you have to do is go to the pharmacy and your pharmacist will take care of everything. You won't have to make 2 trips to the pharmacy or wait until an effective date is put into the computer. Go back to the example of Ed on Page 3. This is how spend-down will work in this situation.

Question: I have QMB Medicaid and a spend-down. I'm on oxygen and the bill for renting the tank gets faxed to my spend-down clerk every month to meet my spend-down. I don't pay for this. After the effective date is entered in the computer, I can go get my medicine and Medicaid pays. In January what will change for me?

Answer: The rules change so that you can no longer use an expense to satisfy your spend-down if you have no responsibility for the expense. In this instance, Medicare covers part of the oxygen cost and QMB Medicaid pays the rest. Refer to the example of Nell. Also remember that Medicare Rx will start covering your prescriptions. Information about how spend-down and Medicare Rx work together is on Page 9.

The following example shows how a non-claim of the member's spouse gets applied to spend-down.

BART

Bart's spend-down is $180. He satisfies his spend-down every month with physical therapy and counseling. His wife Betty works, but she doesn't have any insurance. In February, Betty goes to the doctor. The cost is $100. In March, Bart takes Betty's bills to his spend-down clerk at the county Office of Family Resources. He tells her to apply them for April. Here's what happens:

April 1	Bart's spend-down balance is reduced to $80 because the $100 non-claim was applied to spend-down.
April 10	Bart's bi-weekly therapy visit costs $120.
May 4	Bart receives his monthly Spend-down Summary Notice that shows he owes $80 to his therapist. ($100 of his spend-down was already credited with his wife's expense.) The remainder of the bill was covered by Medicaid.

Question: I pay a health insurance premium. Do I get credit for this to satisfy my spend-down?
Answer: Yes. Health insurance premiums are automatically deducted in determining a member's spend-down. You don't have to show proof every month that you paid your premium. However, if for some reason, you decide to drop your health insurance or your premium amount changes, it is your responsibility to notify your caseworker within 10 days.

Expenses that are Submitted to the Local Office of Family Resources
"NON-CLAIMS"

Certain types of medical expenses cannot be filed directly to the Medicaid program. These are called "non-claims". Documentation of these non-claims must be given to the Local Office of Family Resources in order to satisfy spend-down. Most Local Offices have a spend-down clerk to do this job. However, in some situations, caseworkers may do it. So, be sure to ask your caseworker how to submit non-claims.

In order for a non-claim medical expense to be used for spend-down, you must submit a bill or a receipt showing your liability for the expense. For services that are subject to payment by Medicare or other insurance, the expense remaining after Medicare or other insurance has paid on the claim will be allowed. If a statement from a provider is submitted before the provider files with the other insurance or Medicare, the expense will not be allowed.

Types of non-claims:

- Medical services paid for by a state or local program such as CHOICE or Township Trustee assistance. For these expenses, documentation from the provider of the service must be submitted and it must contain a statement from the provider that he or she will bill the state or local program, not Medicaid.
- Medical services received from a provider who does not participate in the Medicaid program;
- Medical services received by non-member spouses and parents whose income was used to determine the spend-down;
- Bills for medical services received before the member became eligible for Medicaid;
- Co-payments required by other insurance coverage and Medicare.

When does a non-claim credit spend-down?

A non-claim will automatically credit spend-down for the month after you give the bill or receipt to your Office of Family Resources. Go back to the example of Bart on Page 4. *However,* you may tell the spend-down clerk or caseworker that you want the bill to credit spend-down in the month of the service or in the month you turn it in.

How do you decide which month to credit spend-down for a non-claim?

Here are some tips that might help:

1. If you satisfy your spend-down every month with your own medical expenses, then it's generally best to let the system apply a non-claim to the month after you turn it in. That way it will reduce your spend-down balance first thing that month and you will owe less on your own medical bills.
2. If you know you won't satisfy your spend-down in the following month, then it won't be helpful to you to apply the non-claim to that month.
3. If your spend-down is already satisfied for the current month, it might work best for you to have the non-claim applied to the next month.

The Medicaid Spend-down Summary Notice

The Medicaid Spend-down Summary Notices will be issued on the second business day of the month. If Medicaid processed spend-down claims or non-claims for you in the previous month, you will receive the Notice. **Keep your Spend-down Summary Notices.** Check them against the bills for payment that your providers send to you. When you have your annual redetermination appointment with your caseworker, it will be helpful if you have the Notices.

The main part of the Notice is a chart for each month in which you received services that Medicaid processed for your spend-down in the previous month. The chart(s) will show exactly how your medical expenses were applied to spend-down and how much you owe your medical providers. Your providers can bill you the amount in the column, "Amount Applied to spend-down".

When can providers bill members for services received?

Pharmacies can bill and expect payment from you when you pick up your medicine. The system they use processes Medicaid claims instantly and they know at the time how much you owe on the pharmacy bill to satisfy your spend-down. Other providers can bill you when they receive their notification from Medicaid of the amount that was applied to your spend-down. They can expect payment from you *after* you have received your Medicaid Spend-down Summary Notice that shows the amount applied to your spend-down for the service. If a provider has a general policy for *all* patients that service will be refused to someone with an unpaid bill, that policy cannot be applied to a Medicaid spend-down member before the member receives the Spend-down Summary Notice.

Question: I didn't get a Summary Notice this month. Is something wrong?
Answer: You will receive a Notice only if your providers filed claims in the month before you got the notice. For example, if you have Medicare, your providers will bill Medicare first. It will probably be a month or two before the claim is filed with Medicaid to apply toward your spend-down. So, you might not get a Summary Notice every single month.

Question: My doctor sent me a bill but the service I received from him did not show up on my Spend-down Summary Notice. What should I do?
Answer: Contact your doctor's office. Your providers may be notified of the amount of their claim that was applied to your spend-down before the Spend-down Summary Notices are issued. It might depend on the timing of their billing cycles. However, they know that they cannot expect payment from you until you are notified. If you cannot resolve matters like this with your provider, please call Member Services at 1-800-457-4584 (toll-free) or (317)713-9627 (Indianapolis calling area).

Question: After my spend-down is satisfied for a month, will the expenses that Medicaid pays for show up on my Spend-down Summary Notice?
Answer: No. The Spend-down Summary Notice only lists claims that have been processed for spend-down.

Question: What should I do if I have checked with my medical provider and Member Services and I still disagree with how an expense was applied to my spend-down?
Answer: You have the right to file an appeal and have a fair hearing with an Administrative Law Judge. The Spend-down Summary Notice tells you how to file an appeal.

Question: I hold power of attorney for my mother and take care of all her business including Medicaid. Will I get the Spend-down Summary Notices?
Answer: Yes. The Notices are mailed to authorized representatives of Medicaid members. If you don't receive the Notices, contact your caseworker at the Office of Family Resources and make sure that you are listed in the eligibility computer to receive the Notices. Keep your caseworker updated on any address changes.

Below is an example of the chart on the Medicaid Spend-down Summary Notice that shows how medical expenses were applied to spend-down.

Medical Expenses Processed for your (month/year) Spend-down

In this example, the Spend-down Summary Notice is received in April and is for expenses processed in March for March's spend-down.

(1) Date of Service	(2) Date Processed	(3) Provider/ Service	(4) Amount Charged	(5) Paid by other insurance	(6) Billed to Medicaid	(7) Amount Applied to Spend-down	(8) See Notes Section	(9) Future Credit	(10) Possible Refund
01-05-06	03-01-06	L. Brown,M.D. spouse office visit	$100.00			$100.00	N		
03-04-06	03-04-06	B. Pharmacy 222 Apple Dr. Anytown prescription	$53.39	$0.00	$53.39	$50.39	F		
03-04-06	03-04-06	B. Pharmacy 222 Apple Dr. Anytown Co-pay	$3.00	$0.00	$0.00	$3.00	C		

1) Date of Service
   This is the date that you received the medical service.

2) Date Processed
   This is the date that the computer processed the provider's claim and determined how much Medicaid would pay and how much should be applied to your spend-down. If the expense is a non-claim that you gave to your Local Office of Family Resources, this date will be the date that the Medicaid computer posted the amount to your spend-down.

3) Provider/Service
This column shows the name and address of the provider of the service. Sometimes this might be a corporate billing office or the name of the group practice that the provider is in. If you don't recognize the name or address shown in this column, please contact your provider. Also, a brief description of the service will be in this column.

4) Amount Charged
This is how much the provider charged for the service. If Medicare or other insurance has paid or will pay, this is the charge for the service before that payment.

5) Paid by Other Insurance
The amount paid by Medicare or other insurance will be shown in this column. Compare this amount to the explanation of benefits or notice that you received from Medicare or other insurance. Any amount over the Medicare or insurance allowed amount, sometimes called the "write off", will not appear on your Spend-down Summary Notice.

6) Billed to Medicaid
This column shows the amount that was billed to the Medicaid program. If Medicare or other insurance did not cover the service, the amount listed will be the provider's full charge. If Medicare or other insurance paid first on the claim, the amount in this column will be the amount remaining. For non-claims this column will be blank.

7) Amount Applied to Spend-down
This is the amount that your provider can bill you. When Medicaid processed this claim you had not satisfied your spend-down yet. Compare this amount to what your provider billed you for the service. Your provider is not permitted to bill you more than what was applied to your spend-down.

8) See Notes Section
This column may display letters like, A, B, C, etc. If there is a letter in this column, you need to check the Notes Section. There is a section of the Spend-down Summary Notice called the "Notes Section". It will show a brief explanation of information about the specific claim. In the above example, The Notes Section would look like this:

Notes Section:

N This is a non-claim expense that you provided to your local Office of Family Resources.

F The co-payment amount for this service is itemized on a separate line.

C This co-payment amount is itemized on the Summary Notice as a separate line item and is part of the total medical expense for the service you received.

Note “N” is displayed for Dr. Brown’s service because it was a non-claim that you turned in to your Office of Family Resources. In this example, the service was in January, the member turned in the bill in February, and told his spend-down clerk to apply it for March spend-down.

Note “F” is displayed for B. Pharmacy because there was a co-payment for this service.

Note “C” explains that the amount in the column is the co-payment that was charged for B. Pharmacy’s expense.

9) Future Credit

Any amount shown in this column has been carried forward to be applied to spend-down in a future month. Usually, it will be applied to the next month.

10) Possible Refund

If changes were made to claims previously processed, and you might be due a refund from the provider, the amount of the refund will be in this column. A “Note” will be listed on the Spend-down Summary Notice that explains the reason for the refund. This can happen if your spend-down amount was lowered, you turned in a non-claim for the month, or the system made a claim processing correction. Your provider is also notified when this happens.

Help with Problems and Questions

These new changes will streamline the spend-down procedures beginning January 1, 2006. With any change this significant, there will likely be questions when you start receiving your Spend-down Summary Notices and provider bills. There are specialists who can help you. Call Member Services at 1-800-457-4584 (toll-free) or (317)713-9627 (Indianapolis calling area).

Spend-down and Medicare Rx

The new spend-down rules and procedures coincide with the start of the new Medicare prescription drug benefit, Medicare Rx, on January 1, 2006. If you met your spend-down under the “old way” in August, September, October, November, or December of 2005, you will be enrolled in Medicare Rx (Medicare Part D) for the entire year of 2006. You can accept the plan that the federal government picks for you, or select a different one. Be sure to select the right drug benefit plan that that covers the medication you are taking.

Also, if you met your spend-down in August – December of 2005, you are automatically eligible for the year 2006 for the “*Extra Help*” (Low Income Subsidy) that pays for the premiums, deductibles, and coverage gaps of the Medicare drug benefit. Your eligibility for the Medicare Rx *Extra Help* will continue through 2006 even if you lose your Medicaid.

I didn't meet my spend-down in August – December of 2005. What should I do?

The first thing you need to know or find out is whether you have benefits under the Medicare Savings Program as a "QMB" or "SLMB". Your caseworker or spend-down clerk at the Office of Family Resources can tell you. If you have this coverage, then you are automatically eligible for the "*Extra Help*". You won't have prescription drug coverage unless you enroll in a Medicare Rx plan, or satisfy your spend-down. You can select a Medicare Rx plan when open enrollment begins on November 15, 2005.

If you are not eligible for the Medicare Savings Program, contact the Social Security Administration (SSA) and apply for the Medicare *Extra Help*, if you haven't already done so. Contact them at 1-800-772-1213, apply on-line at www.socialsecurity.gov, or visit your local SSA office.

If I satisfy my spend-down the "new way" in 2006, will I be eligible for the *Extra Help?*

Yes, for the remainder of the year.

When I have Medicare Rx, can my prescriptions still be used to satisfy my spend-down?

Generally, no. Federal law does not permit Medicaid to pay for Medicare approved prescription drugs. Under the spend-down rules, if a medical expense is subject to payment by Medicare, it cannot be used to satisfy spend-down. The exception is that Indiana Medicaid will cover Medi*care* excluded drugs that Medi*caid* covers. An example is prescribed over-the-counter drugs. The co-payments that you will owe under your Medicare Rx plan can be used for your spend-down. Take your bills and or receipts to your local Office of Family Resources as explained on Page 5.

The changes to
Medicaid Spend-down
Start
January 1, 2006